Washington School for the Deaf

Post High School Program

Health Packet

Post High School Program
Washington School for the Deaf
611 Grand Blvd / Vancouver, WA 98661
(360) 696-6525 (V/TTY) / (800) 613-4228 / www.wsd.wa.gov

WASHINGTON SCHOOL FOR THE DEAF

Participant Health Record 2012-13

STUDENT NAME: _____ SEX: ____ DOB: _____

Medical Permission	Yes	No	Restrictions
Local physicians and physicians contracted by WSD may provide emergency treatment .			
I AGREE TO RECIVE EMERGENCY TREATMENT BY LOCAL CONTRACTED MD's.			
My physician may be contacted as needed.			
I give permission for WSD staff to act on my behalf when making emergency medical decisions should I be unavailable in an emergency.			
WSD nurses and delegated staff may administer prescription medications, over the counter medications and treatments (including ear cleaning) prescribed by a licensed physician. Please note any medications or treatments that should not be given related to allergies or health conditions.			
Nurses may convey medical information that will be kept confidential, as they perceive beneficial, to staff working with participants.			
I agree to work with the WSD nurses to self-administer all medication and treatments. I agree to inform WSD nurses of all prescription/OTC medications.			

Medical History	
Health Conditions that are Life Threatening: Any condition that is life threatening, according to RCW 28A.210 Sec. 1) requires that a nursing plan be in place before the student attends PHSP.	Please note any health condition that are life threatening: (asthma, seizures, diabetes, allergies, etc.)
Please list allergies to medication, food, or insect sting:	
Special Instructions:	
Please list all chronic and acute medical conditions or concerns.	
Emergency Contact Information:	
Special Diet:	Reason:
Activity Restriction:	Reason:
Insurance Information	
Name & Address of Insurance Company	Policy & Group Numbers/Union & Local

I am responsible for providing payment or medical insurance coverage for myself including medical expenses, evacuation and/or emergency transportation charges. Washington School for the Deaf does not provide medical insurance coverage and will not be held responsible for medical expenses under any circumstance. Note: We would appreciate your bringing insurance card so we can make copy during registration.

Signature _____ Date: _____

Washington
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Attention Participants

If you need to take medications, this form must be signed by your doctor and kept on file at the Washington School for the Deaf

Your Name_____DOB_____

Physician/Primary Care Provider Information	
Physician's Name (printed):	Clinic's Name:
Address:	
Phone:	Fax:

Medication	Dosage	Route	Times per Day	Reason for Med

Allergies_____

Provider Signature required for prescription medication(s), diet plan, and/or activity restrictions.

Physician Signature _____Date: _____